Tonya Boyd, PsyD, LLC

Psychologist Resident
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(503) 840-2053

Request/Authorization to Release Confidential Records & Information

A. By signing this form, I, (clients full name) _____authorize the use and disclosure of my individually identifiable health information to/from:

_____
Person and Agency Represented (If applicable)

_____
Address & Phone/Fax Number

B. **Purpose of Disclosure**: Mental Health Treatment Planning and Continuity of Care. Health information that may be used or disclosed through this authorization is as follows:

_____ Assessment/Treatment /Coord. of Care ___ Eligibility Determination ____ Legal/Court/Corrections/Probations

_____ At the request of the client ___ Other: _____

C. **Specific Information to be Disclosed**: By **initialing** next to a category listed below, I specifically authorize use of confidential information.

_____ Psychiatric and Mental Health information as included In the records.

_____ Alcohol and Drug Treatment information (Specifically protected under law)

_____ AIDS/HIV/other STD testing information (Specifically protected under law)

_____ All health information about me as described above, *excluding* the following: _____

_____ Specific health information including only: _____

_____ Mail records certified if indicated by Tonya Boyd PsyD, LLC

D. I give permission to release my records from the following dates:

_____ _____
(approximate start date of treatment from provider above) (approximate end date of treatment from provider above)

E. I understand that my records are protected under the federal and state confidentiality regulation, including HIPPAA, CFR 42 Part 2, RCW 71.05, 70.02, 71.34, 74.04, 13.50.100(4)(b) and WAC 388-865-0436 or its successor, and cannot be disclosed without my written consent unless otherwise provided in regulations. I also understand that I may revoke this consent in writing at any time, but that in any event this consent expires automatically in **180 days** or shall remain in effect for the period of time reasonability needed to complete the request. I understand that I may refuse to sign this authorization and that such refusal will not affect my ability to obtain treatment from Dr. Tonya Boyd.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. I understand that, except when I am receiving health care solely for the purpose of creating Information for disclosure to a third party, I may refuse to sign this authorization.

Date: _____ Signature of Client: _____

Print Clients Full Name: _____

Client's Birthdate: _____ SS# _____

Date: _____ Signature of Parent/Legal Representative*: _____

*When client is not of legal age or competent to give consent